BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS
125 S. Main Avenue
Sioux Falls, SD 57104
http://medicine.sd.gov SDBMOE@state.sd.us

Dear Applicant:

If you have ever held a certificate to practice as a Physical Therapist Assistant in South Dakota at any point in the past, do not attempt to apply using this process as your certification has been forfeited by statute. If you wish to reinstate and renew, please email (sdbmoe@state.sd.us) or otherwise contact the Board office in writing for instruction and be aware that this can be a lengthy process.

Note: the Board strongly suggests that applicants not make commitments to start practicing in South Dakota until licensure is granted. Some applicants make commitments to start work at a certain time and later find that the commitment cannot be kept. Every applicant has a unique history and the Board can not promise that an application will be processed in any given amount of time. The speed with which applications are processed depends on how quickly applicant initiated information arrives and the completion of a background investigation. Communication regarding the application shall be in writing and directly between the Board and the applicant.

The information contained herein is vital to the successful completion of your application and timely consideration of your request for licensure. Please use the instructions and checklist to complete this application. The application process will be delayed by the following factors, including but not limited to: illegibility, incomplete or inaccurate information, failure to enclose the required fee and documents, failure to arrange for the required applicant initiated primary source verifications, failure to answer all questions completely and accurately. If you have questions about the application or attached forms, please email (sdbmoe@state.sd.us) or otherwise contact this office in writing before you return your application.

If you received this application from a source other than directly from this office or its official website, the application may be outdated or not an official version. To ensure you have the official version, please contact this office. Application forms will be rejected if not on the current version.

Instructions for completing the South Dakota Board of Medical and Osteopathic Examiners Licensure Application

Application Fees: Enclose the $60 fee. The fee is non-refundable and any application received without the appropriate fee attached will be rejected.

Application Instructions: The application and attachments should be printed legibly in Blue or Non-Black ink, or preferably, electronically typed and generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Processing and investigation may still be necessary even after arrival of all applicant initiated documentation; mere arrival of documentation does not necessarily mean the license is issued immediately.
Complete the application as instructed in each section. Please see below for additional instructions on completing the application and additional documents that need to be submitted to the board. Unless specifically requested in writing by Board staff or by official Board application or request forms, do not fax any documents to this office.

Additional Instructions – please see below additional instructions for completing specific sections of the application.

- Verify Required Education (Section 4, Page 4)
  - List each school/program you have attended in order to complete the educational requirements for licensure in your field.
  - Submit **FORM #2** to each educational program you have listed.
- Verify State Licensure (Section 6, Pages 5 and 6)
  - List the requested information for each state where you have ever been licensed or certified.
  - Submit **FORM #1** to each Board or State agency for verification to be sent to us directly.
- Chronology of Activities (Section 7, Pages 5 and 6) and Employment Verification
  - When listing activities, LEAVE NO GAPS IN CHRONOLOGY.
  - If the practice or organization is no longer open, attach a separate sheet listing name, address, and phone number of someone who can verify your time there.
  - If you left any practice or organization under any condition, other than voluntary, please attach a separate sheet listing the condition under which you left.
  - You will be notified if the Board requires verification of any portion of the Chronology section, in which case you will be provided with a form to send.
- Required Disclosures (Pages 8 and 9)
  - These questions must be completed by the applicant. Please provide a complete and signed explanation for any affirmative answers on a separate sheet. Date and Sign the bottom.
- Required Fee (Page 10)
  - Fee Payment Information. Check or credit card options. Date and sign the bottom.
- Affidavit (Page 11)
  - This must be notarized.
- Authorization and Release (Pages 12 and 13)
  - Sign and date the authorization and then send this form to each entity where you held privileges, were employed or practiced as listed in Section 10 of this application.
- PTA Supervision Registration Form **(FORM #5)**
  - This form is to be completed and signed by the proposed PT supervisor.
  - It must be sent directly to the Board from the supervisor.
  - Do not fax, and only send original forms.

Additional Documents – submit the following documents to the Board (if applicable):

- Malpractice Claims Information (Section 8, Page 7)
  - After completing this section, attach a copy of the complaint including your response to the complaint and level of participation. It is your responsibility to provide external verification (i.e. statement from an attorney, court records, etc.) of your response.

The original completed application (copies will be rejected), attached documents and appropriate licensure fee must be sent to the following address:

South Dakota Board of Medical and Osteopathic Examiners
125 South Main Avenue
Sioux Falls, SD 57104

Application for Physical Therapist Assistant (PTA) Licensure Instructions

Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. There is a checklist below.

ANNUAL RENEWAL: Please note that the PTA annual renewal date is **January 1**. If you are completing this application near this date, please contact the Board office to acquire the renewal materials. Licensure granted at anytime before the renewal date, no matter how close, must be renewed if you wish your license to be in good standing for the next year. Unless renewed, licensure granted before January 1 is no longer valid January 2.

Required $60 Fee (Check or Credit Card)	☐
Completed Application	☐
State Licensure Verification form sent to the Board from all states in which you have ever held any healthcare license	☐
Enclose the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	☐
Notarized copy of birth certificate or current, valid passport	☐
PTA Education Verification form sent to the Board by all PTA schools attended – include a copy of your diploma (must be sealed by your school)	☐
PTA school transcripts sent to the Board by your PTA school	☐
Examination transcripts sent to the Board	☐
PTA Supervision Registration Form Sent to Board	☐

It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.

Application for Physical Therapist Assistant Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name _____

First Name _____

Middle Name _____

Suffix _____

Maiden Name _____

_____
All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

Practice Address

☐ Public Access

☐ Mailing

Street _____

City _____ State/Province _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

Home Address

☐ Public Access

☐ Mailing

Street _____

City _____ State/Province _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

3. Identification: You must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

/ /

Date of Birth (mm/dd/yyyy) | Birth City | Birth State/Province | Birth Country

Gender | Social Security Number | NPI Number | Are you a U.S. Citizen? ☐ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI , please go to http://www.cms.hhs.gov/NationalProvIdentStand/.

4. PTA School: List all PTA schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. You must complete the attached "Required Education Verification" form (**FORM #2**) and send it to all PTA programs you have attended. You must include a copy of your diploma to which the PTA program must attach their seal prior to forwarding it to this Board. Additionally, the PTA school must provide this Board with an official copy of your transcripts. The PTA program must forward all documentation directly to this Board.

4. PTA School (attach additional pages if necessary)

1. School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

2. School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

5. Examination:

Please review the instructions of this application if you have questions about taking the FSBPT exam.

1. Have you taken the Federation of State Physical Therapy Board's exam? ☐ Yes ☐ No

1a. What is your score? _____ A minimum score of 600 is required.

1b. Location (state only) of examination: _____ Note: If not South Dakota, you will need to transfer your scores. Please review the instructions of this application.

2. Have you registered to take the exam? ☐ Yes ☐ No ☐ N/A

1b. Location (state only) of examination: _____ Note: If not South Dakota, you will need to transfer your scores. Please review the instructions of this application.

6. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of PTA certification/license/registration. You must also complete the attached "Licensure Verification" form **(Form #1)** and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

6. State Certifcation – PTA certification (or equivalent licensure type) only – attach additional pages if necessary

1. State/Province _____ License Number _____ Status _____ Issue Date _____

2. State/Province _____ License Number _____ Status _____ Issue Date _____

3. State/Province _____ License Number _____ Status _____ Issue Date _____

4. State/Province _____ License Number _____ Status _____ Issue Date _____

5. State/Province _____ License Number _____ Status _____ Issue Date _____

6. State/Province _____ License Number _____ Status _____ Issue Date _____

7. State/Province _____ License Number _____ Status _____ Issue Date _____

8. State/Province _____ License Number _____ Status _____ Issue Date _____

9. State/Province _____ License Number _____ Status _____ Issue Date _____

10.State/Province _____ License Number _____ Status _____ Issue Date _____

All Other Health Care Licensure/Certification (e.g., RN, PA, OT, AT, EMT etc.) - attach additional pages if necessary.

1. State/Province _____ Type_____ License Number _____Status_____Issue Date_____
2. State/Province _____ Type_____ License Number _____Status_____Issue Date_____
3. State/Province _____ Type_____ License Number _____Status_____Issue Date_____
4. State/Province _____ Type_____ License Number _____Status_____Issue Date_____
5. State/Province _____ Type_____ License Number _____Status_____Issue Date_____

7. Chronology of Activities: List ALL activities (PT related or not) in chronological order beginning with PTA school graduation to the PRESENT date, using MONTH and YEAR. For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address. If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. DO NOT SUBSTITUE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical administrative duties.

7. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1 From: Month: _____ Year: _____ To: State/Province Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
2 From: Month: _____ Year: _____ To: State/Province Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Dates: From/To	Practice/Employment
3 From: Month: _____ Year: _____ To: State/Province Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
4 From: Month: _____ Year: _____ To: State/Province Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
5 From: Month: _____ Year: _____ To: State/Province Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
6 From: Month: _____ Year: _____ To: State/Province Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

8. Malpractice Liability Claims Information (copy this form to report multiple claims)

Name of patient involved: _____

In which state did the action take place? _____ Case number (if applicable) _____

Which court? _____
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: _____

☐ Open (pending) ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Other _____

Amount of judgement or settlement $ _____ Amount paid on your behalf $ _____

Month and year of event precipitating claim: _____

Month and year of lawsuit: _____

Insurance carrier at time: _____

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event:
(Attach additional pages if necessary)

Required Disclosures - Page 1 of 2

ANSWER THE FOLLOWING QUESTIONS. **For any "YES" responses, please provide a complete, signed and dated explanation.**

Professional Questions

Have you, your license or an application for license, whether formally or informally, whether voluntarily or involuntarily:

1. been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, not renewed by, withdrawn or relinquished to any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization? Yes ___ No ___

2. been subject to proceedings or investigations by a licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization to terminate, stipulate, restrict, limit, withdraw condition, reprimand, suspend, revoke, refuse, deny, relinquish, or not renew your professional license? Yes ___ No ___

3. appeared or been requested to appear before any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization concerning any violation by you of any law, rule, or regulation of any state, district, territory or province of the United States, Canada, or other country? Yes ___ No ___

4. been subject to proceedings or investigations (for any reason) by any medical facility or professional society, group, or organization to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, relinquish, withdraw or not renew membership? Yes ___ No ___

5. been notified of a complaint by a medical facility or professional society, group or organization, or any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization? Yes ___ No ___

6. been dishonorably discharged from a branch of the United States military or National Guard? Yes ___ No ___

7. had your membership, participation, clinical privileges, request for privileges or employment terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, withdrawn or relinquished to or not renewed by any peer review committee or organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization? Yes ___ No ___
   Is there a review pending? Yes ___ No ___

8. been reprimanded, censured or disciplined by, or been subject to a corrective action agreement/plan with any licensing or disciplinary board, agency or committee, health-related entity, governmental agency or organization, peer review organization, professional assistance program, third party payer, clinic, hospital, or medical staff? Yes ___ No ___

9. had your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.), or state health insurance program terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, relinquished, withdrawn or not renewed, or is any investigation or proceeding with respect to any such action presently underway? Yes ___ No ___

10. been charged by complaint, information, indictment, or otherwise, of any felony or misdemeanor, other than a minor traffic violation? Yes ___ No ___

11. plead guilty, or plead no contest to, any felony or misdemeanor, other than a minor traffic violation? Yes ___ No ___

12. been convicted of, or received a suspended imposition of sentence or suspended sentence of any kind, to a felony or misdemeanor, other than a minor traffic violation? Yes ___ No ___

13. been accused of or been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive or discriminatory behavior? Yes ___ No ___

14. been reported to the NPDB (National Practitioners Data Bank) or HIPDB (Healthcare Integrity and Protection Data Bank) for any reason? Yes ___ No ___

15. had any cases, whether criminal, civil or administrative (of any kind or description), been brought against you or received notice of intent to do so? Yes ___ No ___

Required Disclosures - Page 2 of 2

16. had any judgments been entered against you in professional liability cases? Yes ___ No ___

17. had any final judgments or malpractice claims paid by you? Yes ___ No ___

18. had any final judgments or settlements or malpractice claims been paid on your behalf by another entity? Yes ___ No ___

19. are there any malpractice challenges pending against you at this time? (Including any pending claims, lawsuits, judgments, and/or settlements.) Yes ___ No ___

20. Has any liability insurance carrier cancelled your coverage? Yes ___ No ___

21. Have you been denied coverage or been rated at a higher than average risk class for your specialty? Yes ___ No ___

22. Has your carrier excluded any specific procedures from your insurance coverage? Yes ___ No ___

Health Disclosure Questions.

1. Do you have a physical, mental or emotional condition which would preclude you from performing the essential functions of your practice? Yes ___ No ___

2. Have you ever been treated, hospitalized or confined for any Mental Health issue, including but not Limited to: Acute Stress Disorder, Anxiety or Mood Disorder, Bipolar Disorder, Major Depressive Disorder (recurrent or single episode), Obsessive-Compulsive Disorder, Alcoholism or Alcohol Abuse or Drug Use? **(If yes, please provide letter from treating physician along with your explanation.)** Yes ___ No ___

3. To the best of your knowledge, information or belief, has any person or entity ever reported or suggested to you, or as a result of a self-evaluation, have you concluded that your use of alcohol or drugs has affected your ability to provide appropriate care to patients or to otherwise perform the usual and necessary functions of you medical practice without posing a health risk to your patients? Yes ___ No ___

4. Are you currently using illegal drugs or prescription controlled medications in an illegal manner? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) Yes ___ No ___

5. Have you used illegal drugs within the last two years? ("illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal Law." The term does not include, however, the unlawful use of prescription controlled substances.) Yes ___ No ___

Print Name of Applicant: _____ Date: _____

Signature: _____

Required Fee

I enclose the fee of $60.00 for application for South Dakota ceritifcation

Make Check payable to: SDBMOE
or
complete below for credit card:

Credit Card number: _____

Expiration Date: mm/yy _____

Print Name of person signing credit card: _____

Signature _____Date _____

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physical Therapist Assistant Certification and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice physical therapy.

_____
Applicant's Signature (must be signed in the presence of a notary)

_____
Applicant's Printed Last Name

_____
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

_____
Date of Signature

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

NOTARY

Dated_____ Signed_____

State of_____ County of _____

SUBSCRIBED AND SWORN TO before me this_____ day of, _____ 20____.

My commission expires:_____ (NOTARY PUBLIC SIGNATURE & SEAL)

Standard Agreement

I am aware of the Health Insurance Portability and Accountability Act of 1996 (thereinafter called HIPAA) and understand the provisions dealing with the privacy of my medical records. With such knowledge an understanding, I agree to the following, for the purposes of South Dakota licensure matters only:

a. I do hereby authorize the use or disclosure of my health information by the South Dakota Board of Medical & Osteopathic Examiners (SDBMOE), for purposes of licensure in the state of South Dakota.
b. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and hospitals, and treatment for alcohol and drug abuse.

I further release, discharge and exonerate all third parties or person(s) from any and all claims, damages, and liabilities of any nature, who in good faith and without malice, release the HIPAA information to the SDBMOE for purposes of South Dakota licensure only.

Authorization and Release

Any references to the terms "Users" or "Users of this Application" in this authorization shall include the following entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners together with its board members, staff members, legal counsels, investigators, agents, employees, contractees, and authorized representatives hereinafter collectively referred to as SDBMOE;
2. Any other state or national medical licensing, medical reporting or medical regulatory board;
3. The Federation of State Medical Boards;
4. Any other South Dakota or United States agency in furtherance of and incompliance with SDBMOE's duties and responsibilities under the South Dakota Medical Practices Act and its administrative regulations.

I am the person described herein. I have not engaged in any acts prohibited by the criminal or medical statutes of the State of South Dakota. I am the person named on any diploma or certificated that I have received, I am the lawful holder of said diploma or certificate, and the diploma or certificate was given to me in the regular course of instruction and examination without fraud or misrepresentation.

The following deals with SDBMOE consulting with and receiving information from third parties:

I authorize SDBMOE to consult with any third person or party who may have information or evidence concerning my professional, ethical, mental and physical qualifications, or any other matter that SDBMOE deems relevant regarding my continuing qualifications for licensure with SDBMOE. These third persons and parties include hospitals, institutions or organizations, my references, physicians, therapists, previous and present employers, past and present business and professional associates, and local, state, federal or foreign governmental agencies and instrumentalities, courts of any jurisdiction, associations, institutions or law enforcement agencies, together with their representatives thereof, who have custody or control of any documents, records, information or evidence that SDBMOE deems relevant to my Application. **I specifically authorize any state, federal or international law enforcement agency to conduct a background investigation and to report the findings thereof to the SDBMOE.**

I authorize such third persons and parties to unconditionally release to SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data or evidence whether favorable or unfavorable that SDBMOE deems relevant to licensure, and to permit the SDBMOE to inspect, receive, and make copies of such documents, records, evidence, and other information for SDBMOE's evaluation of my professional, ethical, mental and physical qualifications that SDBMOE deems relevant to licensure.

I release, discharge and exonerate from any and all claims, damages and liabilities whatsoever such third persons and parties, together with their authorized representatives, who in good faith and without malice, consult with and release to SDBMOE such information, evidence, files or records requested by SDBMOE that SDBMOE deems relevant to licensure.

Continued on next page

***I declare and affirm under the penalties of perjury that**:*

This application for licensure, which includes all the information I have provided and the questions I have answered in the application, have been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I state unconditionally and without reservation that I absolutely understand each and every question contained in this application for licensure, that I and I have answered all of them completely and truthfully. If any user discovers any derogatory information regarding my personal background that was not disclosed when completing this application, the users may immediately cease all processing of this application, and I agree that such non-disclosure shall disqualify me for licensure in South Dakota.

I understand and agree that my submission of this application and actions subsequent thereto, but prior to licensure, shall bear directly upon my qualifications for licensure, and I fully understand that the SDBMOE may consider all such actions in its determination whether to grant licensure. To that end, I agree that any unprofessional or harassing behavior on my part, or on the part of any agent of mine, with the SDBMOE's members or staff shall establish grounds for the immediate cessation of all processing of this application and disqualify me for licensure in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the SDBMOE, and I will not assert that any other entity, judicial, or otherwise, may make such determination. I understand and agree that cessation of processing of this application by the users as a result of the acts of omissions by myself as described in this paragraph shall not require the SDBMOE or any other users of this application, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing or any other due process rights, or any other statutory or constitutional rights that I may enjoy pursuant to SDCL 1-26, SDCL 36-10, the South Dakota Constitution, or the United States Constitution. I hereby waive any and all due process rights and any other statutory or constitutional rights that I may enjoy as it relates to all matters described above and in any manner related to this application.

Applicant Name: _____ Date: _____

Applicant Signature: _____